FAMILY PSYCHIATRIC ASSOCIATES

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NOTICE OF PRIVACY PRACTICES

Receipt and acknowledgement of Notice

Patient/Client Name: _____

DATE OF BIRTH: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Family Psychiatric Associates' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Kimberly J. Carr, LCSW

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate! etc.). Legal authority documentation must be provided to the office.

☐ Patient/Client Refuses to Acknowledge Receipt

_____

Signature of Staff Member

Family Psychiatric Associates
Notice of Privacy Practices

Use and Disclosure of Protected Health Information

Section I: PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Family Psychiatric Associates may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen we will display the new policy and effective date at each of our Family Psychiatric Associates locations. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our **Notice of Privacy Practices.**

Patient's Signature _____ Date _____

Print Full Name _____

Section II: CONSENT FOR USE AND DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent. I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Family Psychiatric Associates for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at time of the service in accordance with the contracted Insurance carrier agreements.

Patient's Signature _____ Date _____

Print Full Name _____

Section III: PERSONAL REPRESENTATIVE, FAMILY, OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name or specifically identify these persons and/or other entities you are authorizing to make use of an/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

Name of Authorized Person or Entity Relationship _____ Phone Number _____

Name of Authorized Person or Entity Relationship _____ Phone Number _____

Section IV: AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

Family Psychiatric Associates physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Health care Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____ (Initial) Yes, I agree to allow Family Psychiatric Associates physicians and healthcare staff to leave messages that include Protected Healthcare Information on all three communication devices: home, work, and cell phone.

_____ (Initial) Yes, I agree to allow Family Psychiatric Associates physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following: Please initial next to the applicable communication devices: _____ home number, _____ work number, or _____ cell number.

_____ (Initial) No, I do not agree to allow Family Psychiatric Associates physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work, and cell phone.

_____ _____

Patient's Signature Date

For FPA Internal Use Only

Section V: UNABLE TO OBTAIN NOTICE RECIEPT ACKNOWLEDGEMENT

Option 1: I could not obtain a signed Notice Receipt Acknowledgment from the patient for the following reason:

_____

_____

Option 2: I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on _____/_____/_____, but was unable for the following reason:

_____

_____

_____ _____

FPA Employee Signature Date

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.